Questions

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23. How can treatment providers find out what recovery support providers are in their area? Will there be a directory of recovery supports providers for the state?
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44. For how long a period of time is a voucher valid?
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46. Who is the contact/what is the process for getting technical assistance for billing processes?
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55. Under primary recovery plus grant, what is:
    Relapse Prevention Counseling: **
    Vocation Support: **
    Family Conference: **
    Naltrexone Medical Services:
    Drug Testing: One Screening per client per week:
    HIV Pre and Post test counseling:
    TB Post Test Counseling:
56. Is the original GPRA outcome measurement completed during the intake/assessment process a billable service or is it part of the assessment package price?
57. Can recovery support services (such as pastoral counseling) be provided by a credentialed person/church group AT the treatment site?
58. Regarding vouchers: are the dates set/filled in by the computer or do counselors enter dates? If counselors enter dates, should they put in short time periods in order to monitor clients involvement in treatment?
59. Does "add package" take the place of entering changes in CTRAC??
60. Can faith-based and other nontraditional providers who are credentialed to provide recovery support services refuse to serve a client (i.e. someone with a felony conviction)?

61. Who does the proposal for transportation go to?
62. Will there be a voucher for each recovery resource or will it all be on one?
63. How often do I need to go into the Voucher Management page of the Outcomes Web to update the voucher?

Update added 05-05-05

64. When we do an "assessment update" for a client that has been readmitted to our agency within 180 days, what does the procedure include?
65. The ASI Mini is still on the Outcomes Web. Are we still required to use it?
66. In PR+, are we required to do Clinical Review requests for clients who are under involuntary detention (96-hour holds and 30-day holds)?
67. How do we enroll a client into our ADA program who is already receiving CPS services from our agency?
68. .Does the diagnosis field in CTRAC need to be completed for PR+ clients?
69. .Do we need to print a copy of the treatment voucher and if so, what should we do with it?
70. Do we need to print a copy of the treatment voucher and have the client sign at level change?
71. What should we do with the recovery support vouchers?
72. .Are SATOP clients part of ATR?
73. We converted existing clients to PR+ on April 1. Are they eligible for recovery support services?
74. Should we continue to administer the ASI-Mini as a follow-up tool for CSTAR after April1?
75. If a clients starts as ATR and transfers to CSTAR, can they continue to receive vouchers for recovery support services?
76. Does participation in on-line recovery support group activities count as participation in meetings that support recovery per the GPRA tool, Section F, Social Connectedness?
77. The system won't allow us to add residential support to the voucher at a later date; we must add it at the time of the intake and the counting of the 21 days starts that Friday when the patient doesn't actually receive the service until the following Monday (lack of room or has issues to resolve first). How do we handle this?

Questions and Answers

Q1. If a client is level 1 and then goes level 2 at a different site, do they discharge and re-admit (current practice) or keep the client episode open but transfer the location code somehow?

A Clients should not be discharged and then re-admitted when moving from different levels of service within the same agency, even if they are going to a different physical location. One of the goals of ATR and PR+ is to increase length of stays in treatment (or provider episode), therefore, when clients move to different levels of service within the same agency, the data should not reflect numerous discharges and readmissions to treatment.

There is a procedure in CTRAC that allows you to transfer a client to a different Site Code (location code) and Program Code (level of service) without having to discharge and readmit. Close the Program Episode in CTRAC and open a new Program Episode using the correct Site Code and Program Code. Each level of care has a different program code. To further clarify, in CTRAC, a Provider Episode means the same thing as "Client Episode" in the treatment world, and Program Episode refers to "Level of Care".

If you need assistance in this process, please contact the Department of Mental Health's Customer Support Center toll free at (888) 601-4779. You may also contact Mark Shields or Debbie McBaine at the Division of Alcohol and Drug Abuse. A more detailed explanation can be found in the CTRAC Online Users Version at: http://www.dmh.mo.gov/ois/ctracguide.pdf.

Q 2.Under PR+ does 1.0 = 1.25 (paperwork conversion billing practice)?

A One hour of service equals one hour of service. As in CSTAR, any billable unit of individual or group counseling service includes only time spent face-to-face with the client. Non-encounter time is not reimbursable.

Q 3.Which billing method is utilized? The one time per month that is done with CSTAR or the submit invoices anytime as with current primary recovery programs?

A Invoices may be submitted at any time as they have been with current primary recovery programs, and frequent submission is preferable.

Q 4. What is the process for clinical review?

A If a client's services will exceed the Customary Service Authorization (CSA) for a given level of care, then a Clinical Review Form (available on the Web site at www.dmh.mo.gov/ada/provider/forms.htm) is faxed in advance to Jodi Frederick at (573) 751-9296. Under CIMOR, this process will be electronic.

Q 5.How do we get reimbursed for employees time in the training today?

A A contract amendment is forthcoming.

Q 6. If a client comes in at level 2 and relapses can the provider move them to level 1 without utilization review?

A Movement from a less intensive level of care to a more intensive level requires clinical review.

Q 7. Do Clinical Treatment programs do standard means on clients in PR+?

A Yes.

Q 8.Do Recovery Support programs do standard means on clients in PR+?

A No.

Q 9. What employee credentials or training is required to provide Trauma Counseling?

A Trauma Individual Counseling must be provided by a licensed mental health professional who is a qualified substance abuse professional (QSAP) with specialized trauma training and/or equivalent work experience.

Q 10.What specialized training or work experience are required to provide Trauma Counseling?

A At this point we will just look for evidence in the personnel file that the person is a licensed mental health professional and qualified substance abuse professional with *any* documented training or supervised work experience in the area of trauma.

Q 11. Is there a standardized Trauma Training?

A The 2005 Spring Training Institute will offer multiple opportunities for trauma training. Seeking Safety is the recommended model for substance abuse programs. More information regarding Seeking Safety can be found at http://www.seekingsafety.org. If your agency plans to utilize a different trauma recovery model, please contact Rosie Anderson-Harper at rosie.anderson-harper@dmh.mo.gov.

Q 12. Is there a matrix of PR+ services with staff qualifications listed for each service?

A Qualifications for delivery of specific services are detailed in contracts and certification standards. However, since this question was asked, we will develop a services matrix with staff qualifications and post it on the ADA Web site.

Q 13. Is case management utilized to engage clients or to coordinate services?

A Both.

Q 14. If a client is to be discharged from a provider for non-compliance, for example, can they then choose to go to the other provider they chose?

A Yes—same as it works now.

Q 15. Will a list of Service Providers available within the 100 mile radius be printed out as part of the voucher or at least be a part of the automated system?

A Under CIMOR, yes. Until then, however, providers can keep a hard copy of certified providers within a hundred mile radius and show it to clients so that they may choose.

Q 16.Is the client choice of a provider within a 100 mile radius of the client's address or the Service Providers address?

A Under CIMOR, it will be the client's address. Until then, it can be the provider's address. Without an automated system, it would be too cumbersome to ask providers for more.

Q 17. Would someone be able to be a Recovery Support Services provider on an individual basis or would the person have to be affiliated with an approved or certified agency?

A The current requirement is that the credentialed provider be an organization, not an individual.

Q 18. Is there a list of the agencies that completed the ATR Training/Addictions Academy in January?

A A list of credentialed recovery support providers will be given to each agency prior to implementation of ATR and will be updated on an ongoing basis as additional providers are credentialed. This information will also be posted to the Division's Website. A list of Addictions Academy graduates and organizations that attended the ATR educational meetings is being compiled and will be distributed to all providers in the near future. Treatment providers are encouraged to make contact with these and other faith-based and nontraditional providers in their regions to engage them in the Access to Recovery project as providers of recovery support services. Organizations that have previous experience in this area will be in the best position to become credentialed to provide ATR recovery support services.

Q 19.How much $ does it cost to get credentialed as a recovery supports provider?

A There is no cost to become credentialed as a provider of recovery support services. Key staff of the organization are required to complete the Addictions Academy, a 32-hour course on substance abuse, and there is a $25 deposit to register. But this is refunded to individuals after they complete the Academy. Start-up funds are not available, so again, organizations that have already been providing these types of services will be in the best position to participate in ATR.

Q 20.How long does it take to get credentialed as a recovery supports provider?

A Organizations will be notified of their status within 30 days of receipt of application. Incomplete applications will take longer to process.

Q 21. Are there descriptions of the PR+ services? How can providers access descriptions and staff qualifications to provide various billable PR+ services (e.g., trauma counseling)?

A .Contract amendments are forthcoming that will contain both descriptions and staff qualifications. In addition, we will develop a services matrix with staff qualifications and post it on the ADA Web site.

Q 22.How will people who are enrolled in residential treatment at the time of the conversion to PR+ on April 1 be handled?

A The provider will need to close the current Program Episode and open a new Program Episode using the new Program Code for PR+ w/Residential Support (146).

Q 23. How can treatment providers find out what recovery support providers are in their area? Will there be a directory of recovery supports providers for the state?

A A list of credentialed recovery support providers will be given to each agency prior to implementation of ATR and will be updated on an ongoing basis as additional providers are credentialed. A master directory will be posted on the ATR Web site.

Q 24. How long after a voucher is issued can a person be reassessed for another level of care?

A Nothing about the voucher system prevents a person from moving to another level of care when it is clinically appropriate for them to do so. The only constraint is that movement to a *more* intensive level of care must be authorized through the clinical review process.

Q 25. At the state level, have the judicial systems and probation and parole personnel been informed of the changes in primary recovery programs?

A Yes, it is an ongoing process.

Q 26. How will PR+ services work seamlessly with drug court contracts?

A They should work better than the residential treatment model because they are more flexible. We cannot promise "seamless" yet but are headed the right direction.

Q 27. How will utilization and review be structured and handled with PR+ providers?

A If a client's services will exceed the Customary Service Authorization (CSA) for a given level of care, then a Clinical Review Form (available on the Web site at www.dmh.mo.gov/ada/provider/forms.htm) is faxed in advance to Jodi Frederick at (573) 751-9296. Under CIMOR, this process will be electronic.

Q 28.What advice is there for agencies that are experiencing many repeat (revolving door) detoxes? What services can be billed during a detox in addition to the $75 per day?

A Persons in detox are not in the Access to Recovery project. They do not enter ATR until their detox episode is ended. Only the detox per diem may be charged.

Q 29.Will there be funding for the lab work required for naltrexone to be prescribed?

A No, which is among several reasons that naltrexone therapy is not for everyone.

Q 30.If a person drops out of treatment for longer than 60 days and then re-engages in treatment, does the person need to go through another full evaluation/intake process?

A It depends upon where the person re-enters treatment. If it is at the same provider, then an Assessment Update (interview plus ASI Mini) along with the full ATR (GPRA) outcome measurement tool is required. If it is at a different provider, then the full assessment is authorized and full ATR (GRPA) is required.

Q 31.Can an individual (employee) from the treatment agency do "double duty" if associated with a recovery support agency? In other words, in addition to treatment services they provide, could they also bill for a service they would provide through the recovery support agency?

A This would be allowable as long as the "double duty" did not create a dual client relationship that was unethical or clinically inappropriate. ADA would require that such dual employment be approved in advance in accordance with the personnel policies of the treatment agency.

Q 32.Can alumni groups of the agency be considered a nontraditional provider?

A The alumni group must meet the same criteria as do all other Recovery Support providers. Those criteria are on the ATR Web site.

Q 33.Do the providers need to get additional contact information from clients upon discharge (names/numbers of relatives, friends, etc.) for the MIMH follow-up study?

A No. Clients will be contacted by a tracker, a University of Missouri employee, prior to discharge to obtain an informed consent to participate in the follow up study. The tracker will obtain information about the client's planned living situation and collateral contacts at that time.

Q 34.What about involuntarily committed clients? Do they still keep them in a bed for the 30 days?

A Clients under 96-hour involuntary civil detention remain in detox until their commitment expires or they are no longer dangerous to themselves or others. Similarly, clients under 30-day civil detention stay in treatment with residential support until their commitment expires or they are no longer dangerous to themselves or others.

Q 35.What are the staffing requirements for residential support?

A Same as for residential treatment. The standards have not changed.

9 CSR 30-3.140 Residential Treatment
(3) Safety and Supervision. The residential setting shall ensure the safety and well-being of persons served.
(A) Staff coverage shall ensure the continuous supervision and safety of clients.
1. There shall be an adequate number of paid staff on duty (awake and dressed) at all times. At least two (2) staff shall be on duty, unless otherwise stipulated in these rules or authorized in writing by the department through the exceptions process. Additional staff shall be required, if warranted by the size of the program and the responsibilities and duties of the staff members.
2. Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

Q 36. Can a sponsor be considered a significant other for family therapy?

A No, not for family therapy.

Q 37.Do the time frames for the assessment (72 hours for level 1) remain the same?

A Certification standards allow 72 hours for completion of assessment for clients admitted to Level 1 with residential support, and three visits for clients in any level of outpatient service. Assessment should be completed as close as possible to the time of admission to treatment, but we realize that there are factors that sometimes get in the way. Existing certification standards will not change.

Q 38.How should treatment centers work with faith-based providers who have conflicting philosophies about treatment? (For example, one of their church based support groups discourages clients from attending AA/NA meetings)?

A Treatment providers should advise their clients of recovery supports that are appropriate for them based on needs identified in the comprehensive assessment. The key thing to remember about the Access to Recovery program is that clients are to have free and independent choice of their treatment and recovery support providers. Therefore, treatment agencies will not be referring clients to recovery support providers; rather, they will be informing them of the recovery support providers that are available within their area and the services they have to offer.

Conflicts such as the one indicated above one should be reported to Committed Caring Faith Communities (CCFC) or the ATR Project Director.

Q 39. How would crisis counseling provided over the telephone to existing clients be billed?

A We do not have a service code for telephone crisis counseling.

Q 40.A question was raised about clients who will no longer be eligible for $149 in emergency food benefits (that the agency uses for food) if they are not in residence for 30 days. Yet, the agency will probably still be responsible for food for a larger number of clients attending intensive outpatient level of treatment?

A The PR+ model offers enhanced reimbursement rates that should help with these costs.

Q 41. If a client is attending level I services without residential support, what requirements will we hold the agency to regarding provision of meals?

A 9 CSR 30-3.130 requires that a light meal be served for individuals that receive services for a period of four or more consecutive hours.

Q 42.Will clients currently enrolled in CTRAC on April 1 need to be deleted and re-enrolled in PR+ATR system?

A On April 1 current clients will need to have their Program Episodes closed and open a new Program Episode using the appropriate new Program Code for PR+. This is simply transferring them to a different Program Code and does not require clients to be "deleted" and "re-enrolled".

143 PR+ Social Setting Detox

145 PR+ Outpatient

146 PR+ w/Residential Support

147 PR+ Modified Medical Detox

148 Recovery Services

Q 43. Who will provide ongoing monitoring of the faith-based organizations?

A Committed Caring Faith Communities (see ATR Web site) and the Division of Alcohol and Drug Abuse.

Q 44.For how long a period of time is a voucher valid?

A The voucher is valid as long as the client is engaged in treatment. It ends when the client has been discharged by the provider or there has been no voucher activity (no services) for 60 days.

Q 45.How will treatment providers know if clients are using vouchers as intended?

A Good communication with providers of recovery supports will always be crucial. Monitoring capabilities will be enhanced under CIMOR.

Q 46.Who is the contact/what is the process for getting technical assistance for billing processes?

A Submit a request via fax or e-mail to your District Administrator.

Q 47.Dual clients may continue to need a connection to treatment and the agency after 6 months. The agency goal for these dual clients is to reduce usage, which may reflect a lower rate of abstinence for the agency. Can the fact that they work with so many dual clients be taken into account?

A Clients with co-occurring disorders may require treatment over a longer period of time than clients with a substance abuse disorder alone. The Division expects treatment to be individualized for all clients. Treatment plans with special needs can be submitted to the Clinical Review Unit.

The Federal Government has established abstinence as the goal for federally funded treatment. Abstinence is a reasonable goal for individuals with co-occurring disorders, even if it is not achieved quickly.

Comparisons between treatments must take into account differences in client characteristics. However, all providers serve a significant number of clients with dual disorders.

Q 48.Does the ATR/GPRA tool replace the ASI mini?

A Yes and no. The ATR/GPRA tool is an outcome measurement instrument and must be administered in accordance with federal guidelines—at admission, 30 days after admission, every 60 days thereafter, and at discharge. *Consequently, the ASI Mini will no longer be required for follow-up.*

However, the ASI Mini will not disappear from the Outcomes Web. It will remain an option for assessment updates for clients that are readmitted to the same agency within a six-month period.

Q 49. We had training yesterday. I was wondering about the CAGE-AID screening. We don't have that. Haven't used that. Can I get a copy?

A **The CAGE-AID is** currently on Outcomes Web. Due to the fact that it is operating from a different server, you will be prompted to enter your user name and password before you can complete it even though you have already signed on to Outcomes. This is another process that will be streamlined when we switch to CIMOR.

Q 50.Do you have a list for our area for Recovery Supports or know when that would be available.

A Will be available soon and forwarded to providers.

Q 51. If we have someone who can meet criteria for recovery support services but is not a graduate, can we bill for it?

A Treatment providers do not bill for Recovery Support Services. That is the job of Recovery Support providers. However, in order to be eligible for Recovery Supports, a client must be engaged in treatment services.

Q 52.Outcome Measurement, what is the definition of this service?

A The Outcome Measurement unit of service equals 15 minutes for administration of the GPRA Tool, which will appear as a tab in Outcomes Web as "ATR."

Q 53. What is the procedure to access assessments that other programs did on the outcomes?

A Not available yet, but will be available in CIMOR. The Division issued an assessment policy that will become effective April 1 allowing providers to invoice for full assessments on new clients or those that have not had a full assessment within 180 days *at the same organization*. Clients that have had an assessment within 180 days at the same organization are authorized only for an assessment update—up to four units of individual counseling (including administration of the ASI Mini).

Q 54.We are looking at structuring this a little better. Do we have to open a separate file for the family member or can it be billed as codependency counseling under the client's number?

A Certification standards at 9 CSR 30-3.100 (Service Delivery and Documentation) state that services available to families shall include family therapy and individual and group codependency counseling. The program is not required to establish a client record for a family member if group education is the only service provided to the family member. A separate record is not required for Family Conference, which is a new service under PR+. It is still, however, required for any "codependency" therapy, whether individual or group.

Q 55.Under primary recovery plus grant, what is:
Relapse Prevention Counseling: **
Vocation Support: **
Family Conference: **
Naltrexone Medical Services:
Drug Testing: One Screening per client per week:
HIV Pre and Post test counseling:
TB Post Test Counseling:

A Your contract amendment will provide definitions of these services.

Q 56. Is the original GPRA outcome measurement completed during the intake/assessment process a billable service or is it part of the assessment package price?

A It is a separate unit of service. Providers may bill one unit of "Outcome Measurement—Admission Baseline" for initial administration of the GPRA tool (also called the "ATR Assessment").

Q 57.Can recovery support services (such as pastoral counseling) be provided by a credentialed person/church group AT the treatment site?

A Yes.

Q 58.Regarding vouchers: are the dates set/filled in by the computer or do counselors enter dates? If counselors enter dates, should they put in short time periods in order to monitor clients involvement in treatment?

A Counselors enter the dates in accordance with client needs and funds available.

Q 59.Does “add package” take the place of entering changes in CTRAC??

A Voucher management transactions are not reflected in CTRAC, so the answer is No.

Q 60..Can faith-based and other nontraditional providers who are credentialed to provide recovery support services refuse to serve a client (i.e. someone with a felony conviction)?

A Recovery support services should be available to all clients who are engaged in clinical treatment and receiving services through ATR funding. If provider refusal becomes an issue, the ATR Project Director or staff of Committed Caring Faith Communities should be contacted immediately.

Q 61.Who does the proposal for transportation go to?

A PR+ providers may provide transportation services to clients through subcontracts with credentialed recovery support providers. Reimbursement rates and limits must be approved by the Division of Alcohol and Drug Abuse. Therefore, prior to entering into a subcontract for transportation with a recovery support organization, the treatment provider should submit such proposals to the appropriate District Administrator.

Q 62.Will there be a voucher for each recovery resource or will it all be on one?

A Clients who are receiving recovery support services from multiple providers should be issued a separate voucher for each service. This is necessary for client confidentiality purposes and to avoid confusion.

Q 63.How often do I need to go into the Voucher Management page of the Outcomes Web to update the voucher?

A The Voucher Management page should be edited any time there is a change in clinical services or recovery supports. For example, it must be updated when:

- A client changes level of care in treatment (for example, moves from Level I to Level 2);
- A client needs a new recovery support service or changes recovery support providers;

- An authorization amount for a particular recovery support is increased.

The Voucher Management section gives you access to reports that tell you how much you have left to spend on any given voucher and when the vouchers expire. Providers that fail to update the Voucher Management page to accurately reflect the client's current service package will jeopardize reimbursement for those services.

Update added 05-05-05

Q. 64. When we do an "assessment update" for a client that has been readmitted to our agency within 180 days, what does the procedure include?

A. **According to contract language, the assessment update "shall consist of a client demographics update in Department's information system and also an update of the alcohol and drug domains of the Addictions Severity Index (ASI)."**

- **The demographics update can be accomplished in the Outcomes Web as part of client enrollment.**

- **Since you cannot make changes to the old ASI, "updating the alcohol and drug domains" simply means asking the client about alcohol and drug use since discharge from the last treatment episode and recording the information in the client record. A QSAP may bill up to four units of individual counseling for gathering this and any other information necessary for level of care determination and treatment planning. The assessment update may be documented in a progress note or on a form specified by your agency.**

  NOTE: This is completely separate from the issue of ATR Assessment (GPRA tool). The ATR Assessment is to be administered for *any admission*, regardless of whether it is a new client or one that is being readmitted to your agency, and you may bill one unit of Service Code 31094H, "Outcome Measurement—Admission Baseline" for doing it.

Q. 65.The ASI Mini is still on the Outcomes Web. Are we still required to use it?

A. **Since implementation of the GPRA tool (ATR Assessment) on April 1, there is no longer a need for the ASI Mini. The tool is *not* required by ADA but will be left on the Outcomes Web for providers should they have a use for it. (Providers may choose, for example, to use the ASI Mini to structure the Assessment Update—though again, the ASI Mini is not required for that purpose.)**

Q. 66.In PR+, are we required to do Clinical Review requests for clients who are under involuntary detention (96-hour holds and 30-day holds)?

A. No. The clinical review requirement is waived for clients who are under active involuntary detention of any duration.

Q. 67.How do we enroll a client into our ADA program who is already receiving CPS services from our agency?

A. This scenario is quite possible for providers that have both an ADA and CPS contract. If you have a CPS client that is coming into your ADA program, enrollment will need to work as follows:

1) **In CTRAC, open the appropriate ADA PR+ program episode;**
2) **In Outcomes Web, do the CAGE-AID and ATR GPRA;**
3) **In Outcomes Web, go into Voucher Management and open an assessment voucher;**
4) **Do the assessment in Outcomes Web;**
5) **Return to Voucher Management and enter the appropriate clinical treatment voucher.**

Q. 68.Does the diagnosis field in CTRAC need to be completed for PR+ clients?

A. A diagnosis is not required for PR+ clients; therefore, this CTRAC field need not be completed.

Q. 69.Do we need to print a copy of the treatment voucher and if so, what should we do with it?

A. Yes, you must print a copy of the treatment voucher. After advising a client of treatment options and informing the client about free and independent choice of providers, obtain the client's signature where indicated on the voucher. A copy should be given to the client and a copy retained in the client record.

Q. 70.Do we need to print a copy of the treatment voucher and have the client sign at level change?

A. No, client signature is required only on the initial treatment voucher.

Q. 71.What should we do with the recovery support vouchers?

A. After the client has been advised of recovery support options and providers, print the voucher and obtain the client's signature. A copy should be retained in the client record. The client should take a copy to the recovery support provider on the first visit.

Q. 72.Are SATOP clients part of ATR?

A. No

Q. 73.We converted existing clients to PR+ on April 1. Are they eligible for recovery support services?

A. Yes, but in order to create a recovery support voucher, the CAGE-AID and the ATR GPRA tool must be administered.

Q. 74.Should we continue to administer the ASI-Mini as a follow-up tool for CSTAR after April 1?

A. No. By July 1, 2005, we will require that the ATR GPRA tool be administered in all adult treatment programs, including CSTAR.

Q. 75.If a clients starts as ATR and transfers to CSTAR, can they continue to receive vouchers for recovery support services?

A. No. Recovery support services are available only for PR+ clients.

Q. 76. Does participation in on-line recovery support group activities count as participation in meetings that support recovery per the GPRA tool, Section F, Social Connectedness?

A. No, on-line support groups should not be counted for this purpose.

Q. 77. The system won't allow us to add residential support to the voucher at a later date; we must add it at the time of the intake and the counting of the 21 days starts that Friday when

the patient doesn't actually receive the service until the following Monday (lack of room or has issues to resolve first). How do we handle this?

A. An enhancement has been added to Voucher Management that will now allow you to edit the date on the voucher for such situations.